



**ARKANSAS STATE BOARD OF NURSING  
DEPARTMENT OF ENFORCEMENT**

**TREATMENT PROVIDER REPORT**

Participant Name: \_\_\_\_\_

Primary Treatment Focus: \_\_\_\_\_

Secondary Treatment Focus: \_\_\_\_\_

Medication	Indication	Dosage & Frequency	Number of Refills

*Please use the back of this form if you need additional space to list medications.*

Participant's current diagnosis: \_\_\_\_\_

Has there been any change in Participant's diagnosis? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Participant's treatment plan, recommendations, and interventions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please submit this form to ASBN staff by the tenth (10<sup>th</sup>) of the following months:  
☐ Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

**Fax: (501) 686-2714 / Email: [lwooten@arsbn.org](mailto:lwooten@arsbn.org)**

\_\_\_\_\_  
(Treatment Provider signature)

\_\_\_\_\_  
(Print name and title)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Address and phone number)